**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
CROWN CHIROPRACTIC

**Respondent Name**
TEXAS SCHOOLS PROPERTY & CASUA

**MFDR Tracking Number**
M4-13-1270-01

**Carrier's Austin Representative**
Box Number 43

**MFDR Date Received**
January 22, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** No position statement provided by the requestor.

**Amount in Dispute:** $300.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

(2) An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title.

(B) if the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection … The provider alleges that they should be reimbursed for the IR evaluation. In reviewing the amount of reimbursement provided to the Provider, it is clear that Provider been reimbursed in accordance with Texas Department of Insurance Division of Workers' Compensation Fee Schedule. Therefore, the Provider is not entitled to additional reimbursement."

**Response Submitted by:** JI Specialty Services, INC

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 23, 2012 | CPT Code 99456-WP | $300.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the medical fee guidelines for workers compensation specific

services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED

**Issues**

1. Is the requestor entitled to reimbursement?

**Findings**

1. 28 Texas Labor Code §134.204 (j)(2)(B) states "If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection."

   Review of the documentation for the disputed service date October 23, 2012, finds DWC-69 report documents in part IV doctor checked off box a which states "I certify that the employee does not have any permanent impairment as a result of the compensable injury – OR -."

   The doctor states in the report that the purpose of the examination was to examine the injured employee to determine MMI/IR. The report provided states under Physical Exam, range of motion to the thumb and hand performed it does not state MMI examination performed for the disputed service.

   CPT Code 99456-WP is not supported. Therefore, no additional reimbursement is allowed to the requestor.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | 9/12/14 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.